Welcome to Fleet Medical Centre

New Patient Questionnaire

Title: Mr/Mrs/Miss/Ms/Dr Other (Please Specify): _____

Surname: _____ First Name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Email address: _____

Address: _____

_____

_____

Postcode: _____ Tel No: _____

Ethnicity

White:

☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish

☐ Gypsy or Irish Traveller ☐ Any other white background (Please specify):

_____

Mixed/Multiple ethnic groups:

☐ White and Black Caribbean ☐ White and Black African

☐ White and Asian ☐ Any other mixed/multiple ethnic background (please specify): _____

Asian/Asian British:

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Any other Asian Background (please specify) : _____

Black/African/Caribbean/Black British:

☐ African ☐ Caribbean ☐ Any other Black/African/Caribbean background (please specify): _____

Other ethnic group:

☐ Arab ☐ Any other ethnic group (please specify): _____

Height	
Weight	
Do you smoke? (Delete as appropriate)	Yes / No
Have you ever smoked?	Yes / No
If you are an ex-smoker when did you stop?	
If you are a current smoker, how much do you currently smoke a week?	
If you are a current smoker, would you like help in quitting? (Please speak to reception)	
How many units of alcohol do you consume in an average week? (Pint of beer—2 units, 175ml glass of wine—2units, Bottle of wine—9 units, Single measure of spirits—1 unit)	

Please circle the number that applies to you for each question:

Questions	0	1	2	3	4	Your Score
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you have scored 5 or more, please complete the following questions:

Questions	0	1	2	3	4	Your Score
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you need an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker veen concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

Your medical history:

Do you live with any of the following conditions? (Please circle)

Diabetes Type 1	Diabetes Type 2	High blood pressure	Epilepsy
Heart Disease	Mental Health	COPD	Asthma
cancer	Deafness/Hard of hearing	Blindness/Partial Sight	Angina

Do you have any known allergies?_____

Have your parents or siblings had any of the following conditions before the age of 60?

Diabetes	Heart Attack	High blood pressure	Asthma
Stroke	Epilepsy or fits	Hay fever	

Other conditions (please specify):

_____

Immunisation History:

☐ 1st Triple and Polio	☐ 2nd Triple and Polio	☐ 3rd Triple and Polio
☐ 1st HIB	☐ 2nd HIB	☐ 3rd HIB
☐ 1st Meningitis	☐ 2nd Meningitis	☐ 3rd Meningitis
☐ MMR	☐ Pre school booster	☐ 2nd MMR
☐ HPV	☐ Pneumococcal	☐ Other (please specify):

_____

What is your first language?_____

Please indicate if you will need the services for an interpreter: Yes / No

Women ages 20-65 only

Have you had a cervical smear test? Yes / No Date of last test (approx.): _____

Was the result normal? Yes / No

If you have had a hysterectomy, please give the approximate date of the operation:

_____

Do you require an advocate? (A person who supports someone who may otherwise find it difficult to communicate or to express their point of view) Yes / No

Do you require written information and correspondence in large print? Yes / No

Do you require written information and correspondence in easy read format? (Where the information uses straight forward words and phrases are used supported by pictures, diagrams, symbols and/or photographs to aid understanding and to illustrate the text) Yes / No

Do you require the use Braille? Yes / No

Do you use British Sign Language? Yes / No

Will you require a sign language interpreter? Yes / No

Do you need a speech-to-text-reporter (STTR)? (An STTR types a word for word account of what is being said and the information appears on screen in real time for users to read) Yes / No

Do you need text relay? (Enables people with hearing loss or speech impairment to access the telephone network. A relay assistant acts as an intermediary to convert speech to text and vice versa) Yes / No

Do you require information or correspondence in audio format? Yes / No

Do you require a longer appointment time to enable effective communication/the accessible provision of information? Yes / No

Are there any special requirements not listed that you need? If yes, please specify below:

_____

_____

Are you happy for us to contact you for medical and administrate purposes via:

SMS (Text) Yes / No

Email Yes / No

Current Medication:

Please attach a copy of you current prescription re order slip or supply the details of your current medication. Please note, if you have regular medication, you will need to book an appointment with your GP.

Medication and dose

Carers:

Are you a carer? If so, please fill in the details bellow:

Are you a carer? Yes / No

What is your relationship to the person you car for? (e.g. spouse, son, daughter, employed carer): _____

Name and address of the person your care for (if registered at the practice):

_____

_____

Summary Care Record

The SCR is an electronic record of important patient information, created from GP medical records. Information in it includes current medication, allergies and details for the patient including their names, date of birth and NHS number. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care. Everybody is 'opted in' and if you are content with this, you do not need to do anything. However, if you are unhappy with this, you will need to opt out. This will be particularly beneficial in situations such as when a patient is in hospital emergency departments of for out of hours clinicians. The information will not be available to everyone, only those with appropriate permissions. Please fill in the form on the next page if you would like to opt out.

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s).....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....

Ref: 4705

Care data

Health and social care is becoming increasingly paperless and digital making it more important than ever to ensure there are robust protections in place to protect the data and information held within it. All health and care organisations that handle sensitive information should be working towards giving patients the highest levels of trust and confidence abd reducing the risk of external threats and potential breaches. In order to achieve the ambition of a fully digital NHS, it is vital that the public trusts health and care staff to keep their personal data safe and secure.

This digital system will allow different agencies from which you receive care, including GP surgeries and hospitals, to have access to information to help them provide the best care possible for the patient.

Your identity will be protected as the information provided include your postcode and NHS number but not your name. How your information is used and shared is controlled by law and strict rules are in place to protect your privacy.

Information which does not reveal your identity can then be used by others such as researchers and those planning health services which could help improve understanding on a national scale of the most important health needs and the quality of the treatment and care provided by health services.

Other benefits of sharing this information include finding more effective ways of preventing, treating and managing illness, guiding local decisions about changes that are needed to respond to the needs of local patients and to support public health by anticipating risks of particular diseases and conditions.

You can opt out of this which will mean that confidential information about you will not be shared or used for any other purpose other than providing your care, except in special circumstances. If you wish to opt out, please fill in the details below. There is also an opt out option that restricts the use of information help by other places you receive care such as hospitals. The information provided below will be then be added to your medical record.

Care Data—Opt out

I do not wish any confidential medical data relating to me to leave my GP Practice.

Name (Block Capitals) _____

Date of Birth _____

Signature _____

Date _____

I do not wish any confidential data gathered from any health and social care setting to leave that setting.

Name (Block Capitals) _____

Date of Birth _____

Signature _____

Date _____